PREMERA CONVERSION STUDY

Report 2

Review of the Literature and Experiences of Other States, and Discussion of Potential Effects of a Premera Conversion

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***Produced for*:**

Premera Watch Coalition
Washington State Hospital Association
Washington State Medical Association
Alaska Blue Cross Conversion Task Force

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I. Introduction

Over the past 15 years, a number of nonprofit Blue Cross and Blue Shield health plans across the nation have converted, or proposed to convert, to for-profit organizations. In 2002, Premera[a] joined this group by announcing its intention to become an investor-owned company. Premera offers health insurance coverage in Alaska through a Blue Cross Blue Shield health plan and in Washington State through a Blue Cross health plan, as well as individual coverage through affiliate companies. The state insurance departments of the Washington and Alaska have the responsibility and authority to review and approve or deny Premera's request.

This report summarizes pertinent research literature and experiences from other states in which such conversions have been proposed or taken place, which provides a context for understanding the potential effects of a Premera conversion. The report then identifies and discusses such effects of the proposed conversion on consumers, providers, other health plans, and the health care markets in Washington and Alaska. These findings are based, in part, on Report 1 of this two report series, which describes the roles that Premera plays in these markets and identifies markets, state residents, and providers that may be most affected by conversion.

Determining the effects of a conversion is a complex endeavor. Every state is different in its regulatory environment, geography, rural/urban mix, and approach to the problem of the uninsured. Every health care market is unique as well, with each having its own history, and with each comprising different arrays of organizations, levels and types of competition, and approaches to health care delivery and financing. Furthermore, the environment in which conversions take place is constantly changing, complicating the analysis of which changes are a result of a conversion and which are due to larger insurance cycles, public policies, or competitive pressures that affect all health plans, providers, and consumers.

To further complicate matters, the role played by Blue Cross and Blue Shield plans in each state also varies widely. In the case of Premera, the conversion will affect two states with very different health care markets—Washington and Alaska. All these issues make it unlikely that the experiences of Washington or Alaska will mirror precisely that of any other *single* state in which a conversion has taken place. By looking at the experiences of a number of other states, however, we will be able to see patterns or themes that are useful in understanding how a Premera conversion is likely to affect consumers and markets in these two states.

Premera's stated reason for wanting to convert is to access equity capital markets. According to Premera, new capital from these markets would "enhance Premera's flexibility and responsiveness to customer needs in an increasingly demanding health-care marketplace," allow the company to "make continued investments in new products and technology, support a growing customer base," and "provide additional resources to support our intent to remain a strong, locally managed independent health plan."[1]

[a] "Premera" is the name of a corporation that comprises a family of companies. Premera is identified by the Washington Secretary of State's office as a "miscellaneous and mutual" nonprofit corporation. Its affiliates include Premera Blue Cross (nonprofit), Premera Blue Cross Blue Shield of Alaska (nonprofit), States West Life Insurance Company (for-profit), MSC Life Insurance Company (for-profit), LifeWise Health Plan of Washington (nonprofit), and LifeWise Health Plan of Oregon (for-profit).

Opponents of Premera's proposal argue that the conversion "will be harmful to Premera's members, subscribers, enrollees, contracting providers and other health care consumers" and may "result in increased rates, fewer benefits in Premera health coverage, less access to health insurance in 'unprofitable' markets (such as rural Washington), and less money spent on health care, while more money is spent on marketing, lobbying, shareholder profits and executive compensation."[2]

II. Methods

The Premera Watch Coalition, the Washington State Hospital Association, the Washington State Medical Association, and the Alaska Blue Cross Conversion Task Force commissioned the University of Washington Health Policy Analysis Program (HPAP) to study the potential effects of the proposed Premera conversion on the health care systems in Washington and Alaska. In particular, HPAP was asked to look at the effects on people covered or potentially covered by Premera, other health plans, providers, individual and group markets, the uninsured population, and publicly subsidized health insurance programs, including Medicaid, State Children's Health Insurance Program (SCHIP), and (Washington's) Basic Health.

This study relies entirely on publicly available information and interviews conducted by HPAP with experts knowledgeable on local or state insurance markets in Washington and Alaska. HPAP does not have access to any internal documents from Premera that would provide guidance on what decisions the company intends to take in the market should it be allowed to convert and, therefore, on what types of effects on the market we should anticipate. As a result, HPAP sought information that would help us understand a broad array of potential effects:

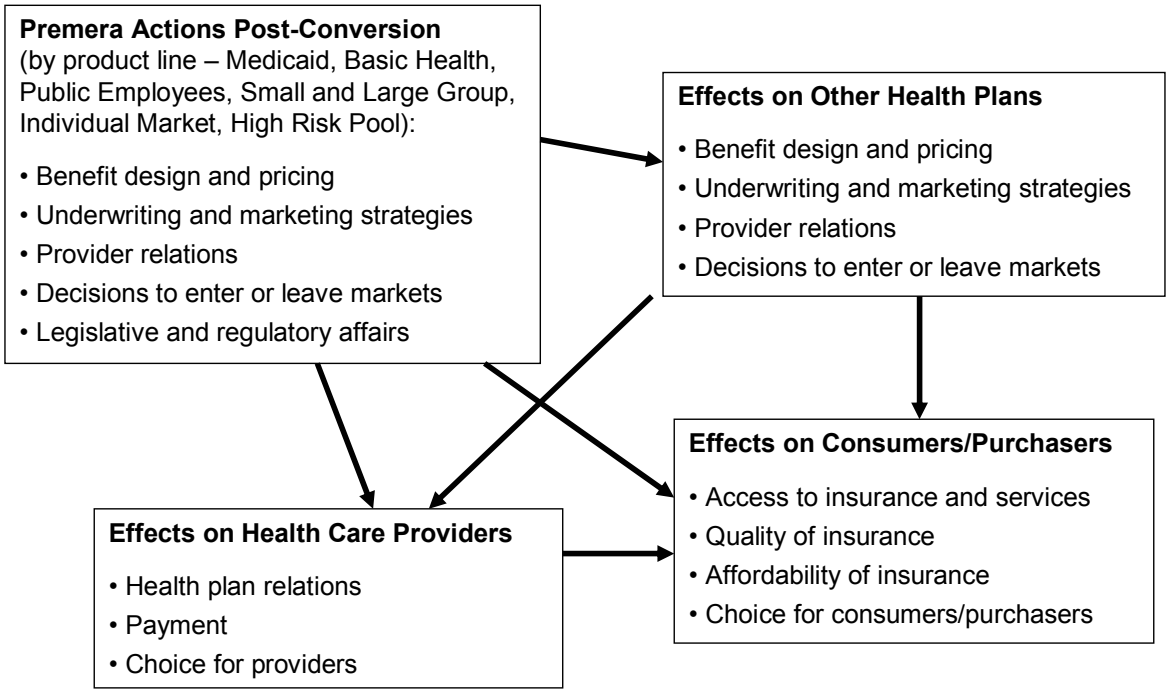
- Effects on specific market segments, including individual, small, and large group coverage, public insurance programs (for example, Medicare, Medicaid), and rural communities.

- Effects on health plan (Premera and others) behavior: including provider contract and payment relations; underwriting, benefit design, and product pricing; spending on medical claims and other costs (for example, administration, profit); community benefits; and involvement in state regulatory and legislative affairs.

- Effects on patients, purchasers, and residents, including access to and affordability of health insurance, access to health services, and quality and customer satisfaction.

Our approach to this project is based on an understanding of how the different parts of the health care financing and delivery system affect each other. Figure 1 on the next page represents these relationships. Such a *systems* approach is important, because each specific segment of the market can significantly affect other segments. Studying how conversions in other states have played out—or were predicted to play out—will help us gain a better understanding of potential market changes in Washington and Alaska.

FIGURE 1. Conceptual Framework of How Premera Conversion Could Affect the Health Care Market and Consumers



After conducting an extensive literature review, HPAP identified 16 states in which Blue Cross Blue Shield plan conversions have taken place in the past 15 years. In addition, we identified three recent proposed conversions (involving four states and the District of Columbia) that were not completed either because the proposal was denied by state regulators or withdrawn by the company. These conversions and proposed-but-not-completed conversions are shown in Tables 1 and 2 on pages 6 and 7, including dates of conversion to for-profit status and acquisition by a national company, if applicable.

To narrow our focus, we reviewed readily available information for these 19 cases and selected 10 for further study, by considering two criteria:

1. *The conversion or proposed conversion or acquisition by a national company occurred within the last five years*. This criterion is important, because health care markets around the country have changed significantly since the mid-1990s and, therefore, findings from older conversions may be less helpful to us. We included the California conversion, despite the fact that it was completed more than five years ago, because it created what is now one of the two largest national health plans that have been buying local BCBS plans.

2. *Availability of good information*. Given the scope of and resources available for this project, we have to rely primarily on existing information. Policy analyses and other types of

research reports were conducted on some but not all conversion cases. This information included both attempts to predict the effects of conversion—often produced on contract to state insurance departments—and efforts to compare market activities pre- and post-conversion.

The ten conversion cases that are the primary focus of this report involve California, Colorado, Georgia, Kansas, Maine, Maryland, Missouri, New Hampshire, North Carolina, and Virginia. A few conversions involved a change in a company from a local nonprofit to a local for-profit; others have involved a simultaneous conversion and acquisition of a local or regional insurer by a national health plan. Conversions in California, Georgia, Missouri, and Virginia did not take place as part of an acquisition, but all four of these converted health plans are now owned by either WellPoint or Anthem, the two major national for-profit Blues plans. Much of the information that we have to rely on stems from conversions that have also involved an acquisition, but we strive to discern the effects of the conversion itself, even though the detrimental effects appear to be worsened in instances in which a conversion is followed by acquisition.

In the past three years, Blue Cross and Blue Shield plan conversion proposals in Kansas and Maryland have been denied, and another in North Carolina was withdrawn. In these states, a significant amount of analytical work was carried out to predict the effect of a conversion.

TABLE 1. Blue Cross Blue Shield Conversions

State/Plan	Conversion of Local Nonprofit to Local For-profit	Simultaneous Local Conversion and Acquisition by National Plan	Post-Conversion Acquisition by National Plan	Current Owner
Blue Cross of California (WellPoint)	1993			WellPoint
Blue Cross Blue Shield of Colorado		1999		Anthem
Blue Cross Blue Shield of Connecticut		1999		Anthem
Blue Cross Blue Shield of Georgia (Cerulean)	1998		2001	WellPoint
Accordia (BCBS licensee for Indiana) (Anthem)	2001			Anthem
Blue Cross Blue Shield of Kentucky	1987		1993	Anthem
Blue Cross Blue Shield of Maine		2000		Anthem
Blue Cross Blue Shield of Missouri (RightChoice)	2000		2001	WellPoint
Blue Cross Blue Shield of Nevada		1999		Anthem
Blue Cross Blue Shield of New Hampshire		1999		Anthem
Empire Blue Cross Blue Shield of New York	2002			Empire BCBS
Community Mutual (BCBS licensee for Cincinnati, Ohio)		1995		Anthem
La Cruz Azul de Puerto Rico (Cruz Azul)	1998			Cruz Azul
South Dakota Blue Shield (Wellmark)	1996			South Dakota BS
Blue Cross Blue Shield of Virginia (Trigon)	1996		2002	Anthem
Blue Cross Blue Shield of Wisconsin (Cobalt)	2001		2003	WellPoint

Note: Most conversions take place over a one- to four- year time period, which allows for analysis, legal filings, and appeals. The date listed in the table is the date the conversion was finally approved or settled.

TABLE 2. Proposed-But-Not-Completed Conversions

CareFirst Blue Cross of Maryland	After merging with nonprofit Group Hospitalization and Medical Services (BCBS of D.C.) in 1998, and BCBS of Delaware in 2000, parent company CareFirst proposed a conversion and simultaneous merger with WellPoint. For the conversion to go forward, the insurance commissioners from all three states would have needed to approve the merger. In 2003, the conversion was denied by Maryland's insurance commissioner, in part based on negative effects of a shift in accountability from a nonprofit mission to shareholders.
Group Hospitalization and Medical Services (BCBS licensee for D.C.)	See CareFirst above.
Delaware Blue Cross Blue Shield	See CareFirst above.
Blue Cross Blue Shield of Kansas	Anthem attempted to acquire BCBSK as part of a proposed conversion in 2001. In February 2002, the state's insurance commissioner denied the BCBSK conversion, citing likely premium increases as one major reason. Anthem appealed the case to the state Supreme Court, which in August 2003 unanimously upheld the insurance commissioner's ruling.
Blue Cross Blue Shield of North Carolina	In 1998, legislation laying out procedures for a BCBSNC conversion was passed by the North Carolina legislature, despite the plan's public assertions a few years earlier that it did not intend to convert. In 2002, BCBSNC filed a conversion proposal with the state insurance commissioner. In June 2003, BCBSNC officials withdrew the proposal, citing the high cost of the proceedings and the risk of being subject to stricter regulations that could hamper their competitiveness.

Source: Consumer's Union. *Conversion and Preservation of Charitable Assets of Blue Cross and Blue Shield Plans: How States Have Protected or Failed to Protect the Public Interest*. November 2002. www.consumersunion.org/health/bcbs1102.htm (July 8, 2003).

HPAP reviewed a summary of extensive interviews with experts in California, Georgia, Missouri, and Virginia conducted for a study of the proposed North Carolina conversion. In addition, we conducted 15 of our own telephone interviews with consumers' groups, medical societies, and hospital associations in California, Colorado, Maryland, Maine, New Hampshire, and Virginia and spoke with four national experts on conversions and for-profit versus nonprofit behavior (see attached interview questions). We also talked with 19 knowledgeable experts on local or state insurance markets in Washington and Alaska. These included interviews with representatives of state and local medical societies and hospital associations, and with a variety of providers who do business with Premera. These providers varied substantially in size and in location within the two states.

This report focuses exclusively on Blue Cross Blue Shield conversions, because Premera is a Blue Cross Blue Shield Association licensee and because very little information is available on conversions of other nonprofit plans to for-profit status. In addition, Blues health plans have historically played unique roles in local and regional health care systems. In most states, Blue Cross and Blue Shield plans initially were regulated separately from other insurers, were allowed to operate as nonprofit organizations, community-rated their insurance products, offered open enrollment periods, and were acknowledged—either implicitly, due to market dominance and pricing or explicitly through state laws—as the insurer of last resort.[3]

The local nature and rapidly changing context of health care markets complicate the study of the effects of conversions. In addition, many Blues plans changed their behavior well *before* they announced their decision to convert to public corporations, blurring the line between their nonprofit and for-profit characters. For example, BCBS of North Carolina, which recently withdrew its conversion proposal, started reducing its medical loss ratios in 1997 to move closer to its major for-profit competitors.[4] Interviewees in Georgia, Missouri, and Virginia reported that their Blues plans had already started acting like for-profit corporations before they attempted conversion.[5] The researchers in the North Carolina case call this complication "conversion as event" versus "conversion as a process."[6] They point out that in order to convert, a plan will take measures to ensure the best possible financial position for itself leading up to the conversion.

National experts on insurance markets and Blues conversions explain that the best strategy for any health plan intending to convert is to be in the strongest financial shape possible at the time of conversion, because this will enhance the value of the stock. A leading industry adviser, for example, recommends that prior to conversion, a Blue Cross plan should "develop a for-profit culture, . . . tighten its medical management, hit its earnings targets and shore up its operating surplus—or leave its conversion plans on the shelf."[7] This phenomenon complicates comparisons of pre- and post-conversion behavior, at least insofar as pointing to differences in behavior in the narrow window bracketing the date of conversion.

Most converted Blues plans have been bought by one of two major national purchasers—Anthem and WellPoint—either concurrent with or after conversion, adding yet another level of complication to this analysis. Much of the information that exists involves health plans that have been acquired by Anthem or WellPoint, complicating the analysis of which behavior changes are related to national-versus-local ownership as opposed to for-profit-versus-nonprofit status. Information focusing solely on the latter factor is harder to come by. However, we believe experiences involving Anthem- or Wellpoint-purchased plans are relevant to the Premera case, because of the high proportion of converted Blues plans that then were purchased by one of these two national companies. Moreover, some of the effects of the proposed conversion are likely to be the same irrespective of a subsequent acquisition of Premera

III. Background on Blue Cross Blue Shield Conversions[8]

Blue Cross and Blue Shield plans have occupied an important, often unique, niche in U.S. health care for more than 70 years. Blues plans have strong local origins, having developed out of local hospital and medical societies, with local representation on their boards. With their roots in the local hospital and physician communities, Blues plans have long had special relationships with health care providers, allowing them to offer very broad networks and to obtain discounts from providers. Blues plans were initially characterized by operating as nonprofits, being "insurers of last resort" (that is, providing insurance coverage to anyone regardless of health status), and offering community-rated premiums (that is, charging the same rate to all individuals in a community regardless of health status). In return for acting in this quasi-public manner, Blues plans often operated under special, less-restrictive regulations and obtained special tax advantages; both circumstances varied by state.

Market pressures, changes in regulation, changes in federal and—in some cases—state tax laws, and changes to the Blue Cross Blue Shield Association (BCBSA) rules have all worked together to change the Blues landscape.

- *Market pressures*. Prior to the 1980s, but accelerating during that decade, other insurers began—in part responding to the demands of some employers—to offer coverage that was experience-rated (that is, charging different rates to individuals or groups depending on their actual use of medical care), thus allowing these competitors to sell less expensive insurance products. Blues plans responded by starting to experience-rate their offerings and, most recently, becoming much more careful about staying in or entering a market in which they lose money. In addition, consolidation in various industries led to demand for health benefit products that were available in many locations, increasing interest in regional or national health plans. Competition and other market pressures led to consolidation among Blues plans, mostly within states, decreasing the total number of Blue Cross and Blue Shield organizations nationwide from 110 in 1982 to 69 in 1994.

- *Tax laws*. Blues plans, like other charitable nonprofit organizations, benefited by being exempt from federal and local taxes. The federal government, however, removed their full federal exemption in 1986. Whether Blues health plans retained special state tax treatment (such as being exempt from premium taxes) has varied by state.

- *BCBSA Rules*. Association rules required that parent organizations of Blues health plans licensed by BCBSA be nonprofits, although Blues plans could have for-profit subsidiaries. In 1994, however, the Association changed this long-standing prohibition against investor-owned licensees. As a result, Blues plans began to merge across state lines and became targets for acquisition by non-Blues health plans.

Today, 42 independent Blue Cross and Blue Shield plans—38 nonprofit and 4 investor-owned for-profits—serve more than 81 million people in the United States.[9] The consolidation and conversion of Blues plans have been driven by the stated desire to attain access to capital, economies of scale, broader markets that can serve multi-state employers, and diversified risk, and to counter the consolidation of other plans. Some observers have also argued that one motivation for conversions is the opportunity of senior executives of Blues health plans to obtain significant economic benefits from stock sales and other monetary incentives. These goals—and the expectation that investor ownership will help attain them—parallel trends among other types of health plans. For example, the proportion of all health maintenance organizations that are for-profit jumped from 18 percent to 75 percent between 1981 and 1997.[10]

A final factor leading to efforts by Blues health plans to convert has been the effect of the insurance cycle (that is, the tendency for insurers to face periods of high premium income compared with their medical expenditures followed by periods of lower premium income relative to such expenses). During the early 1990s, many independent Blues insurers faced a "truly exceptional 'down' portion" of the insurance cycle,[11] leaving some of these health plans financially weak. In these cases, executives of Blue Cross Blue Shield plans argued they needed access to capital markets to survive. Today, however, most nonprofit Blues plans are well within their target ranges on profitability, administrative overhead, and reserves.[12]

IV. Why Do Blues Conversions Matter?

Fundamentally, the difference between nonprofit and for-profit organizations, including health plans, is simple: nonprofits may not distribute earnings to owners, the so-called "non-distribution constraint."[13] Nonprofits do have "owners"—that is, individuals who direct the use of the corporation's assets and activities—and can earn profits, but profits may not be distributed to owners in the form of earnings-conditioned payments, such as annual dividends. The rationale for this constraint is to reinvest earnings in the organization to preserve assets, improve programs or services, and provide community benefits.

Nonprofit organizations usually have formal mission statements that articulate a commitment to community services and community benefits and have governing boards that at least purport to represent the communities the organizations serve. Moreover, nonprofits often are granted exemptions from federal, state, or local taxes, reducing their operating costs and allowing them to provide services at lower prices than taxed organizations. Some nonprofits are also designated as charitable organizations by federal and state governments, allowing contributors to deduct donations from their tax liabilities.

The lines between the behavior of nonprofit and for-profit health plans have blurred somewhat over time as nonprofits faced growing competition from other insurers and pressures from purchasers. For-profit health plans, however, face special pressures from shareholders to meet often-challenging expectations for financial performance that nonprofits do not. Indeed, the movement by some Blue Cross and Blue Shield health plans to convert from nonprofit to for-profit organizations is "substantially altering two unique characteristics of the Blues—local focus and not-for-profit operation—and rendering at least some of the Plans indistinguishable from their for-profit national competitors."[14]

A consumer advocate interviewed for this report said that it was important for health plans to remain nonprofit, because "[w]hen we were dealing with [the nonprofit] BCBS [of Maine], the plan supported things like community rating, but now it is a constant fight. When you keep a plan nonprofit you're keeping the values viable."[15] A market analyst in the North Carolina case, when asked about the differences between for-profits and nonprofits, pointed out that for "9 out of 10 individual decisions . . . they'll decide the same thing, but the issue is what is the impact of the 1-in-10 decision where they will differ?"[16]

A further concern is the potential for purchase of a converted Premera by a national plan and the effects of subsequent non-local ownership—i.e., whether non-local ownership would reduce a health plan's sensitivity and responsiveness to the needs and concerns of the community. This concern is of special importance to Blue Cross and Blue Shield plans, which have historically had close ties to their local communities. A summary of an interview of two market analysts in the North Carolina case reported that the analysts believed that:

> outside ownership "tends to change" how "community oriented" management is, making them less likely to be "swayed" by local concerns. They felt this can result in a "different perspective" under which management is less amenable to making concessions regarding pricing, underwriting, and maintaining certain risk pools. They said that a locally owned BC [Blue Cross] may have more restraint in exploiting market power for pure self-

interest. . . . In the view of one market analyst, this local/outside difference is a far bigger factor than nonprofit vs. for-profit corporate form in shaping corporate attitudes and policies.[17]

FIGURE 2. Accountability and Priorities According To Ownership Status

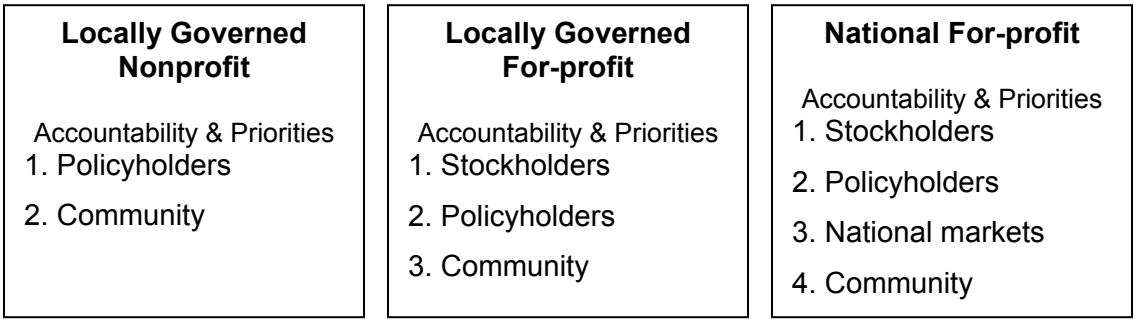


Figure 2 represents a conceptual framework within which to think about how plan ownership—and conversion from nonprofit to for-profit status—may relate to an organization's accountability and market decisions.

At one end of the spectrum is a locally owned, nonprofit health plan that is accountable to enrollees and the community. At the other end is a nationally owned, for-profit health plan whose primary responsibility is to shareholders and policy holders across many markets.

These different priorities might manifest in such decisions as whether to participate in the individual insurance market or Medicaid, how aggressively to underwrite (that is, to analyze the likelihood individuals will need medical care, determine whom to insure, and set the prices of insurance coverage), or how much of the premium dollar is spent on medical claims versus administrative overhead. How a health plan *actually* behaves, however, may vary from this framework because of other factors, such as its history and reputation in the market or the level of competition with other health plans. This study intends to understand whether, to what extent, and in what circumstances, converted Blues plans or those that plan to convert behave consistently with or at variance to this conceptual framework.

Because a converted Premera could become part of a national for-profit health plan—a strong possibility given national trends—this study looks at the differences in behavior and strategy not only between nonprofit and for-profit health plans, but also between local and national ownership (primarily by WellPoint and Anthem). Acquisitions have often been completed as part of a conversion or quickly thereafter, and the few conversions that did not involve purchase by a national health plan have not been well-studied. As a result, we have less information about the effects of a local nonprofit Blues plan converting to, and remaining, a local for-profit. Nevertheless, the pressures associated with a for-profit organization's accountability to shareholders will hold true regardless of whether Premera is subsequently purchased by a national plan, and hence the likely effects of the conversion will apply, at least to some extent, if Premera remains a local for-profit health plan.

V. Premera's Roles in Washington and Alaska—Summary of Findings

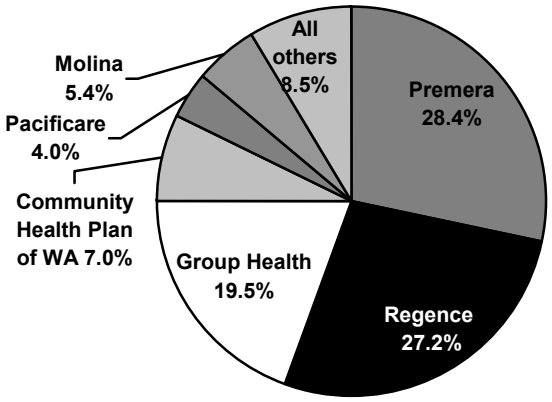
Report 1 describes the roles that Premera plays in various market segments in Washington State and Alaska. We briefly summarize the key findings of that report below:

Washington

- Premera is one of the three health plans (along with Regence Blue Shield and Group Health Cooperative) that account for about three-fourths of the health insurance market, overall. These three plans have dominated the market for more than 20 years.
- Premera is a particularly important player in the individual market (nearly 50 percent of the market) and in rural communities, a status that has remained steady, more or less, over recent years (except in the late 1990s when most health plans froze enrollment in the individual market). In fact, Premera is the only insurer offering individual policies in 9 counties, and one of only two insurers in 17 other counties.
- Premera has participated in all major public health insurance programs in Washington—including Healthy Options (Medicaid managed care), Basic Health, public employees, and Medicare—but it no longer offers a Medicare + Choice product and is exiting the public employees program as of 2004.

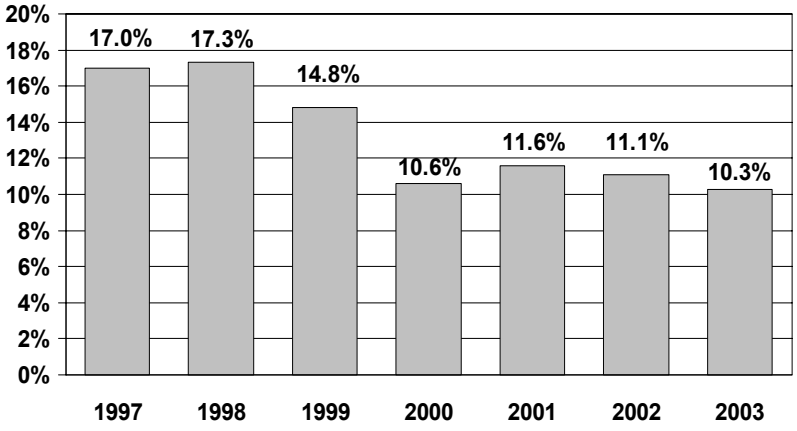
  Premera's enrollment totals for Healthy Options and Basic Health have dropped substantially in the past seven years as has the number of

FIGURE 3. 2002 Washington Enrollment Market Share, Health Care Services Contractor Plans Grouped by Corporate Parent*



* Self-funded employer enrollment not included.
Source WSHA compilation of OIC data.

FIGURE 4. Premera Share of Total Washington Medicaid Health Options Enrollment*



*** Enrollment includes children in BHP+. Data are for April of each year.**

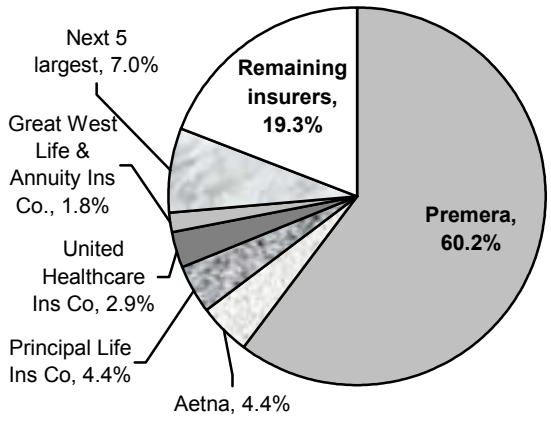
counties in which it serves these two populations. As with individual insurance, however, in those counties where Premera is still involved in Medicaid and Basic Health, it is often a dominant player. For example, Premera covers 50 percent or more of all Basic Health beneficiaries in five counties, all rural.

- The largest segment of Premera's insured enrollees is in the large group market, comprising nearly 57 percent of all of its insured enrollment. Premera is also a substantial player in the self-funded market in Washington.
- Over the past five years, as a percentage of premiums earned, Premera has had higher administrative expenses and lower payments for medical claims than other health plans in the state, on average.
- Premera's relationship with providers appears not to be consistent across the state. In urban areas, where Premera can choose from among multiple providers, the health plan has apparently rankled at least some providers with a "take-it-or-leave-it" contracting strategy.[18] On the other hand, in at least some rural Eastern Washington communities, Premera's relationship with providers appears more collaborative, although contrary views have been expressed by some rural providers. The 1998 merger of Premera with Medical Services Corporation, a Blue Cross plan based in Spokane, has led to some concern that corporate decisions made in Seattle may not be as sensitive to providers on the east side of the state.

Alaska

- Premera plays a prominent role in Alaska's commercial insurance market, accounting for more than 60 percent of total premiums. This major role is consistent across individual, small group, and large group markets.
- Premera's large market share is tempered by two characteristics that make Alaska's health care financing environment different from Washington's. First, more than half of all Alaska residents are either uninsured or obtain health care through mechanisms other than commercial health insurance, including Medicare, Medicaid, native corporations/Indian Health Service, and U.S. Department of Defense.

FIGURE 5. 2001 Alaska Premium Market Share, Top Ten Insurers, and Remainder

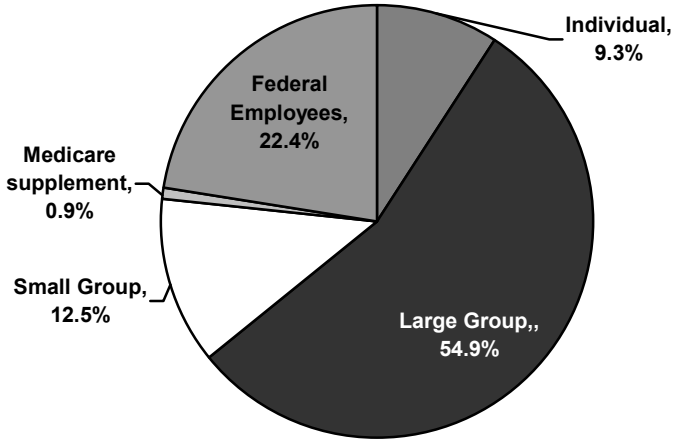


* Employer ("Self-funded") enrollment managed by above carriers not included. Source: Alaska Division of Insurance

Second, Alaska's Medicaid program does not have a managed care component, so this is not a potential market for Premera. On the other hand, the Federal Employees Health Benefits Program is a major sponsor of coverage in Alaska, accounting for 22.4 percent of Premera's enrollment.

- Premera's relationship with providers appears to be somewhat more collaborative than in urban Washington State (although we heard some comments to the contrary), perhaps because of the health plan's long and large presence in the state. Some concern has been expressed that decisions made by the health plan's corporate office in Seattle are not as understanding of or sensitive to conditions in Alaska.[19]

FIGURE 6. Premera Enrollment by Market, Alaska, 2002*



* Employer ("Self-funded") enrollment not included. Source: Annual Statement for the Year 2002 of Premera Blue Cross, and Annual Alaska Health Insurance Surveys–Part 1.

VI. Potential Effects of a Premera Conversion

This section summarizes information from the literature and from the experience of other states, and then, for each area of concern, discusses potential or likely effects of a Premera conversion on Alaska and Washington health care systems.

Potential Reduction in Spending on Health Care

For-profit health plans typically spend less of each premium dollar on patient care and more on administration. When a plan converts to for-profit status, it becomes responsible not only for managing care and administrative costs and for generating surplus for future program needs or expansions, but also for generating profits for shareholders. For-profit health insurers typically seek underwriting gains of 2-3 percent, and these profits must come from somewhere[20]—either less health care (by serving fewer sick people or providing fewer services for all policy holders), more efficient care, or lower administrative costs. Although converting plans argue that these new profits will come from the investments in technology and greater efficiencies that come with growth, the evidence suggests otherwise.

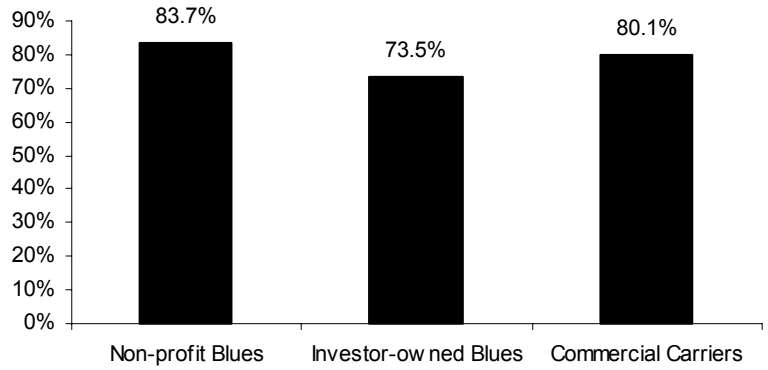
Spending on Medical Care

Overall, for-profit Blues health plans spend less on medical care than nonprofit plans. How much a health plan spends on medical care versus other costs is its medical loss ratio (MLR), expressed either as a percentage of premium revenue or total revenue (for example, premium revenue plus investment income). Nonprofit and for-profit Blues plans differ in how much of their revenues they spend on health care versus other expenses, such as administration. Researchers in the Maryland case summed up this difference:

> In CareFirst's 2001 report the company appears to take pride in a high MLR overall … whereas WellPoint stresses the benefit of a lower MLR as a target in its SEC filings.[21]

This difference in approach to MLR appears to be translated into practice. Investor-owned Blues plans spend considerably less of their revenues on patient care than both nonprofit Blues and other commercial carriers (see Figure 7, below).

FIGURE 7. Spending on Health Care as a Percent of Total Revenue, by Organization Type, 1997-2000



Source: Graph recreated from Schramm, C. *Implications for Health Care Providers Resulting From the Sale of Kansas Blue Cross Blue Shield.* December 2001; 10.

Also, an annual study conducted by the California Medical Association found that of the ten managed care health plans that spent the highest proportion of premium revenue on health care, eight were nonprofit plans.[22]

Other information regarding medical loss ratios involves WellPoint, the nation's oldest converted Blues plan. WellPoint's MLR is about 79 percent, which is lower than all major competitors—6 points below nonprofit California Blue Shield and 16 points lower than nonprofit Kaiser Foundation Health Plan.[23] Similarly, Blue Cross and Blue Shield of Missouri, which converted in 1994 and was subsequently bought by WellPoint in 2002, has since decreased its medical loss ratio 5 percentage points to 78 percent, lower than all of its major competitors, and 5 points lower than the nonprofit BCBS of Kansas City.[24] BCBS of Georgia's MLR remained fairly constant after its conversion to a for-profit in 1996, but it dropped 2 points to 86.5 percent during 2001, the year it was acquired by WellPoint.[25]

Spending on Administration and Other Costs

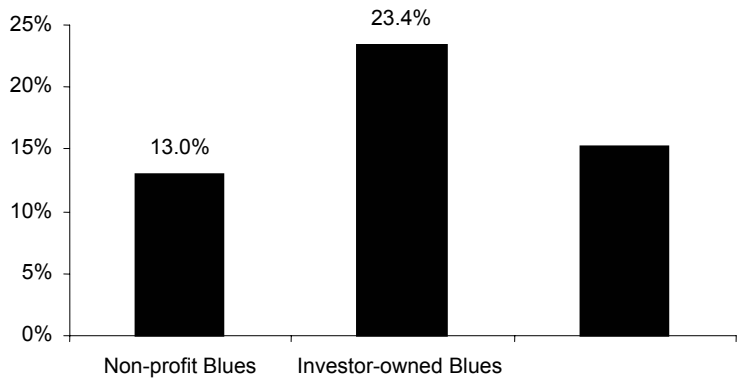
For-profit health plans tend to spend more on administrative costs than nonprofit plans. The administrative cost ratio is the difference between what a plan collects in premiums and what it pays for claims. Administration costs may include profits and their distribution to shareholders. A high administrative cost ratio is not necessarily bad for consumers if the money is being used to better manage care or produce better health outcomes or quality. Comparisons of reported

administrative spending across plans must be done with some caution, because some plans may include a type of expense—for example, for utilization review—as part of administration while other plans include it as part of medical costs.

Two national experts interviewed for this report felt that no plan—nonprofit or for-profit—was managing care well, suggesting that if a plan has high administrative costs it is not likely to be as a result of intensive care management.[26] One of these interviewees said that "what the Blues have to sell is broad networks and superior discounts. Many converted plans also have clever product design that promotes favorable selection. These plans are entrepreneurs not on care management, but on the design of their health insurance products."[27] Indeed, HMOs and other tightly managed care have historically gotten a cool reception from Blues plans.[28]

For-profit Blues spend more on administrative costs as a percentage of premiums than nonprofit Blues or other commercial carriers (see Figure 8).

FIGURE 8. Administrative Expenses as a Percentage of Total Premium Revenue, by Organization Type, 1997-2000

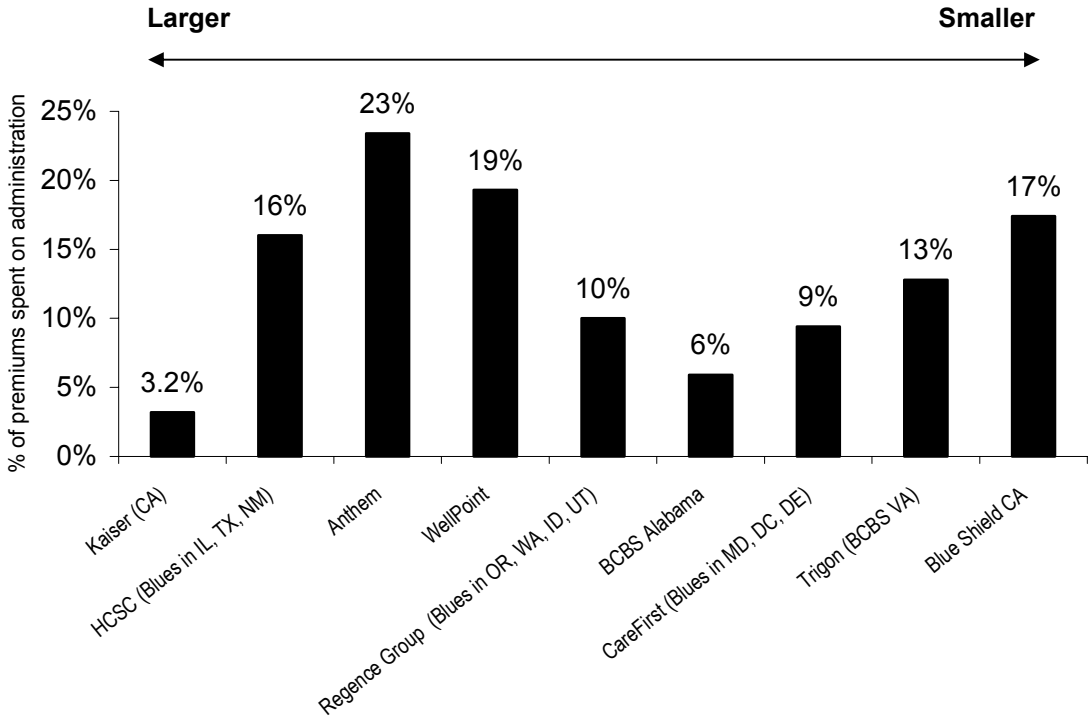


Source: Data from Schramm, *Implications for Health Care Providers Resulting From the Sale of Kansas Blue Cross Blue Shield*. December 2001, 10.

Similar to the changes in its medical loss ratio as a national for-profit health plan, WellPoint's administrative expenses have grown from 8 percent two years before conversion to 14-15 percent in recent years and are now 10 percentage points higher than for nonprofit Kaiser Foundation Health Plan.[29]

Plans proposing to convert argue that new capital will allow them to grow in size and realize economies of scale, but size does not necessarily lead to lower administrative costs because of the complexities of trying to integrate information and claims data systems and because "profit levels in health insurance companies are highly tied to local market knowledge."[30] (See Figure 9, below.) In instances where administrative costs have been reduced after a conversion, medical loss ratios have been reduced at the same time.[31]

FIGURE 9. Administrative Costs as a Percent of Premiums, by Plan Size (2000 revenues)



Note: Graph recreated from Harkey, J. The Blues: Is Conversion Inevitable? *California Market Report* 2002; 1 (1). The performance indicators are from corporate annual reports, except results for BCBS of Alabama and Kaiser, which are from statutory filings, which may differ from annual reports and may not include all lines of business. Revenue includes premiums and other revenue plus earnings from invested reserves. In 2000, Kaiser, Regence, BCBS of Alabama, CareFirst, and Blue Shield of California were locally owned nonprofits, and HCSC was a mutual insurer.

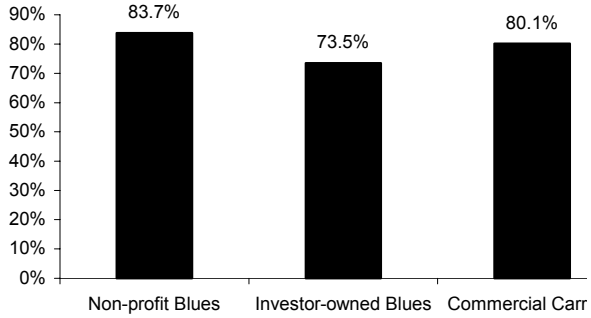
The researchers in the North Carolina case also point out that administrative cost reductions will eventually "bottom out" leaving "profit-maximizing" companies looking for other areas from which to realize profits. Industry analysts interviewed for that study said that "for-profit insurers can be expected to look for profit improvements through every mechanism available."[32]

Potential Effects of Premera Conversion

A converted Premera will likely reduce its medical loss ratio (usually expressed as medical care spending as a percentage of premiums or of revenues) and increase its administrative cost ratio (administrative spending as a percentage of premiums) in order to attain and maintain adequate profit margins. In 2002, Premera had a loss ratio (85.3 percent) that was fourth highest of the six largest health plans in Washington.

A national comparison shows that loss ratios for investor-owned Blues plans have been about 10 percentage points lower than for nonprofit Blues plans.[33] Should a converted Premera mirror this national experience, as much as 10 percent of Premera's revenues that now pay for health care might well be used for non-health care purposes, the equivalent of about $200 million per year (Premera's total revenue in 2002 was just more than $1 billion.) This sum would pay for about 80,000 people on Basic Health in Washington, based on state funding and enrollment in 2003, or cover the average per person health care costs for about 50 percent of uninsured individuals in Alaska.

FIGURE 10. Spending on Health Care as a Percentage of Total Revenue, by Organization Type, 1997-2000



Source: Graph recreated from Schramm, C. *Implications for Health Care Providers Resulting From the Sale of Kansas Blue Cross Blue Shield*. December 2001; 10.

Access to Insurance Coverage

The ability for consumers to obtain insurance coverage is affected by the price of coverage (affordability), the extent to which insurance companies use underwriting practices to exclude high risk individuals, and the potential or perceived potential of health plans to make profits—or at least not lose money—in specific markets (for example, individual coverage, Medicaid, rural communities). Increased premiums, aggressive underwriting, or an exodus from rural areas or public programs by a converted health plan could lead to more uninsured people.

The information reviewed in this report shows a mixed picture of the effects of conversion on access. A report for the North Carolina Department of Insurance discusses why the relationship may not be clear. It suggests that if faced with the possibility that a hospital might close, a Blues plan would be "better off" paying providers more and passing the costs on to enrollees (which could increase the uninsured population). Plans could also form "tiered networks" that pass the higher provider costs on to customers in the form of co-payments and deductibles.

> [G]iven the stark choice between accepting a higher-than-desirable increase in reimbursement rates or not contracting at all—thereby giving customers a much stronger motivation to switch—BCBSNC may be more likely to "blink" in contract negotiations than to accept a hole in its network. So while it is conceivable that a more aggressively profit-oriented Blue might result in more providers refusing to contract, it is not likely that this would lead to entire areas without coverage.[34]

Creating a Charitable Foundation—Effect on Access to Health Care

Many conversions of health plans and hospitals have resulted in the creation of charitable foundations. These new entities often have missions to improve access or health care for residents of the communities previously served by the original nonprofit. For example, the endowments created by the conversion of Blue Cross of California to WellPoint has led over the past four years to more than $100 million in grants to support low-income clinics and to

subsidize a high risk pool.[35] The assets of conversion in other cases, however, may have less direct benefits for access; in New York, nearly all of the assets were used to increase hospital employee wages, and in Wisconsin the large majority went to two medical schools.

Of perhaps greater importance is that the amount of funding made available for access initiatives as a result of conversions is very small compared to the health system, as a whole, and to the assets removed from the public domain, in particular. As a report for the Maryland insurance department notes:

> The (seemingly large) asset bases of BCBS conversion foundations actually represent a very small portion of annual health care expenditures in each state; the income generated from these assets is virtually negligible when compared to total health care expenditures. Thus, the assets from conversion foundations may be most appropriately considered supplemental "problem-solving" resources.[36]

Effect on Premiums

Early national studies have found little difference in the premiums charged by nonprofit and for-profit health plans. However, these studies are of limited value in that they predated the effects of the recession of the early 2000s and do not focus on the effects of conversion from nonprofit to for-profit status. Information from more recent cases suggests that converting health plans may lead to higher premiums.

Insurance premiums for individuals, businesses, and governments have been growing rapidly in recent years because of various market forces, technology, and other factors.[37] To the extent that a converted health plan (or one planning to convert) increases premiums more than it otherwise would in order to improve value to shareholders, more people could become uninsured because they can no longer afford coverage.

The ability of a health plan to increase premiums in this way will be tempered by purchasers' willingness to pay and competition with other plans. In addition, premium changes may also be constrained by a state's regulatory environment, such as the authority of some insurance commissioners to approve rates. A converted health plan may also have to increase premiums because of higher premium taxes imposed in some states like North Carolina. In this case, the additional tax bill could be passed on to consumers in the form of higher premiums.[38] Approval of a conversion may also be contingent on a promise that premiums not be increased for some period of time.

Three major HMO studies conducted between 1986 and 2001 found that premiums in for-profit health plans are either similar to or lower than premiums in nonprofit plans.[39] Information from recent conversion cases, however, raises questions about the extent to which these findings adequately address whether a *converting* health plan is more or less likely to raise premiums.

Pre-Conversion Activities

In August 2002, Blue Cross and Blue Shield of North Carolina increased premiums by ten percent or more for many of its customers in the individual and small group markets while reporting a record profit of $85.6 million. The North Carolina insurance commissioner

suggested that the plan might be "padding their initial public offering on the backs of policyholders," which would "directly contradict [their CEO's] assurances that premiums will not increase as a result of the conversion."[40] BCBSNC was also criticized for reneging on an agreement with the state to provide affordable coverage to those who could not find it elsewhere. The health plan was apparently charging rates nearly 800 percent higher than its standard policy and taking losses of about $100,000; it had initially agreed to take losses of between $2-4 million. How much of this issue is related to BCBSNC's proposed conversion and how much is related to the competitive pressures that have evolved since the promise was made a decade ago is unclear.[41]

Conversion of a Failing Blues Plan

Higher premiums might be expected with the conversion of a health plan that had been taking financial losses, which the new owners must then recoup. In Kansas, researchers predicted that Anthem, the purchaser of a faltering BCBS, would have to raise rates faster than inflation to earn new underwriting gains to pay shareholders.[42] This finding was one major reason the proposed conversion was denied.

Anthem and WellPoint

Studies conducted in the Kansas and North Carolina cases generally found that premiums charged by Anthem and WellPoint in various markets have mirrored rates charged by other health plans.[43] However, the Kansas Insurance Commissioner found sufficient evidence to conclude that "Anthem would raise premium rates in the small group and individual markets at a substantially greater pace than would occur otherwise."[44] A study conducted for the Maryland Insurance Administration raised concerns that premiums for WellPoint could be deceivingly low, since products in the individual market often are limited to catastrophic coverage.[45]

Underwriting and Benefit Design in the Individual Market

The individual insurance market, though often representing only 5 to 10 percent of a state's population, plays an important role in providing access to coverage for self-employed individuals, people whose employers do not offer coverage, and uninsured people. The individual market is risky for insurers, because it is hard to cross-subsidize the medical costs for higher risk individuals with the premiums of enough healthy people. Insurers use underwriting—methods to estimate the expected health care costs for individuals using health status, demographic, and other information—and benefit design to minimize the likelihood they will insure and have to pay for too many people with high medical needs. As a result, individual insurance policies can be very expensive, may exclude coverage for pre-existing conditions or expensive treatments, or may entail very high cost-sharing on the part of enrollees.

Very little information comparing underwriting and benefit design practices by nonprofit and for-profit health plans exists. In addition, researchers working for regulators in other states at times have had a hard time determining the underwriting plans of companies proposing to convert or acquire a Blues plan. In Maryland, for example, WellPoint consistently failed to provide enough information for the insurance commissioner to understand how the plan's profit goals could be met without raising premiums, lowering provider rates, or eliminating coverage for riskier enrollees.[46]

Underwriting Practices

Material reviewed and interviews conducted for this report raise concerns that nonprofit plans will adopt more aggressive underwriting practices prior to announcing their plans to convert.

After dropping out of Maryland's Medicare and Medicaid managed care programs, and just a few years before a proposed acquisition by WellPoint, CareFirst started requiring medical exams before enrollment in their individual products. It did this by using a technicality to get around the state's substantial, available, and affordable coverage (SAAC) program, which prohibited such policies. The result was that almost 30,000 state residents lost their insurance. Without CareFirst's commitment, the SAAC program collapsed in 2002, leaving Maryland without an insurer of last resort or a high risk pool.[47]

After converting to a for-profit organization but before being acquired by WellPoint, BCBS of Missouri eliminated individual coverage for the Farm Bureau's association plan, moving its members to individual policies or the Missouri high risk pool. This decision meant that premiums doubled or tripled for hundreds of members.[48]

Benefit Design Practices

In some cases, benefit design by a converted health plan could lead to further adverse risk selection—and therefore reduced access—in certain insurance markets, especially the individual market. One national expert suggested that the big national plans, especially WellPoint, have "clever product design" that promotes favorable selection and thus ultimately leaves some sicker people without coverage.[49] A consumer advocate in Maine claimed that Anthem has "destroyed our non-group market" by stopping the sale of low deductible policies and limiting its offerings to $5,000, $10,000, and $15,000 deductible policies.[50]

Such benefit design strategies could cause further distortions in the individual market as healthy individuals migrate to high-deductible policies, leading to higher premiums for lower-deductible policies (with fewer healthy people in those risk pools) and eventually more uninsured people. If that occurs, health care providers could be burdened with more uncompensated care. A report compiled for the Maryland Insurance Administration warns of the potential danger posed by WellPoint's catastrophic insurance products, which have high deductibles and co-pays, low maximum lifetime benefits, and "skinny benefits.":[51]

> WP/BCC is felt to provide a minimal amount of coverage for the small amount of money paid. This is a concern since the insurance may only be used for acute care due to its cost and preventive and early treatment of illness will not be utilized, resulting in long-term worsening of health. If copays and deductibles prevent accessing needed care, the insurance that patients are paying for is essentially illusionary.
>
> WellPoint could be criticized for diverting patients from purchasing more rational coverage, since many individuals and families purchase solely on price, not understanding or reviewing what insurance actually covers or costs to use, when considering deductibles and copays. WellPoint sees the uninsured as a potential market. It is felt that such low-cost coverage will not only cause the currently uninsured to buy these insurance "lite" policies but this practice will also siphon off the better-risk or

currently insured individuals (young healthy individuals) from purchasing more comprehensive insurance by encouraging them to buy this less extensive coverage . . . .

This migration away from more comprehensive policies will in turn increase costs to higher risk or older members . . ., especially those with preexisting chronic medical conditions, due to underwriting of a group which is now composed of mostly high-risk individuals. This action will result in more costly insurance that may be unaffordable to the people who need insurance the most . . . . The issue to be considered is whether WellPoint is providing patients' wants/desires for cheap or "skinny" insurance vs. a member's need for adequate insurance with adequate coverage that is affordable when accessed.[52]

Rural Coverage

In many states, Blue Cross and Blue Shield health plans have been important—sometimes dominant—insurers in rural communities, a result of their historical commitment to statewide coverage and broad provider networks. Information from other states reviewed for this report suggest that Blues plans, even national for-profits, may continue to be involved in rural markets, although the pressures of answering to shareholders for losses associated with such markets would tend to suggest otherwise. Some plans might believe that maintaining coverage in rural areas is in their economic self interest.

In the case studies of four states conducted for the North Carolina case, the converted Blues plan "continued to cover their entire geographic regions" and continued their commitments to the individual and small group markets.[53] In 2000, Georgia's Cerulean (WellPoint) reported its intent to "solidify its presence in rural areas and small cities where there is little managed care," suggesting that rural areas may actually play a central role in for-profit and national Blues plan's business strategies.[54]

An interviewee from New Hampshire and others interviewed for this report speculated that some of the larger national plans were actually in a better position to continue serving unprofitable areas because they have "the mother ship that underwrites it."[55] We also heard reports suggesting that the major plans that can afford it will also continue serving unprofitable regions because of "publicity and other things that overwhelm whether they're for-profit or nonprofit."[56] For example, a few interviewees reported that Anthem in Virginia is conscious of its reputation in the eyes of not only regulators, but also the public and the media.[57] In other words, concern about the company bottom line—even if not specific to the losses incurred in a particular region—might drive decision-making with respect to maintaining coverage.

Public Programs

Earlier studies found nonprofit HMOs much more likely to participate in Medicaid and Medicare,[58] but more recently health plans of all types have been and are withdrawing from these programs because of a variety of market factors.[59] In effect, market pressures—including purchaser demands for lower prices, competition with other plans, and low investment earnings—have led to more bottom-line decisions by all types of plans to leave products or markets that are not profitable.

A 2002 study of Medicare managed care, Medicare+Choice (M+C), participation by national plans reveals the market-oriented decision making:

- The study's eight national managed care firms make M+C participation decisions on a county-by-county basis.
- The adequacy of M+C payment rates is the main determinant of the study firms' M+C participation decisions, which is often considered together with the number and intensity of program requirements.
- Second only to the adequacy of payment rates (but not entirely unrelated to it), the study firms' ability to develop and maintain an adequate provider network significantly influences their M+C participation decisions.
- Other factors also influence the study firms' M+C participation decisions including the competitive landscape, the implications for other lines of business and/or products, and pressures from Wall Street.
- M+C participation decisions are made by the study's firms in the context of the overall health care environment that is influencing not only the managed care industry, but the health care industry overall. Current market forces include rising medical costs, consumers and providers pushing back against managed care, provider network instability, and a heightened HMO regulatory environment.[60]

The Community Tracking Study conducted interviews that collected information about 14 nonprofit, mutual, and for-profit Blue Cross and Blue Shield health plans in 12 representative markets across the United States from 1998-1999. At that time, most Blues plans reported they were thinking more about profitability and less about public benefit than they used to when deciding whether to participate in public programs. On the other hand, two nonprofit Blues plan respondents in the Community Tracking Study said that their plan was willing to take a loss on these products, because public expectations of Blue Cross Blue Shield's role remain high.[61]

One national expert interviewed for this report suggested that investor-owned plans will act more "rationally" than nonprofit plans, "so that if they're losing their shirts, they'll get out of the market. If they want to maintain a portfolio that helps them keep their presence in the state market, they'll stay in."[62] A few interviewees for this report, however, suggested that—as with the issue of service in rural communities—the big national plans may have the capacity to take losses on public programs and thus might stay in for reasons other than profit, such as public image. For example, a New Hampshire interviewee reported that Anthem appears dedicated to administering New Hampshire's State Children's Health Insurance Program (SCHIP) program, which they take a loss on.[63] Similarly, researchers in the North Carolina case found that in California, WellPoint has a "strong presence 'across the board'" in public insurance programs, including Medicaid managed care, the state's high risk pool, and SCHIP. Some California sources called WellPoint "about the best" of all private insurers in this regard.[64]

In the end, health plans appear to weigh these various factors to arrive at market-specific decisions about whether to participate in public programs. For example, WellPoint in Georgia is one of only two insurers to stay in the Medicare HMO market, although it reviews its involvement annually. In Missouri, RightChoice, the for-profit Blues plan that was later

acquired by WellPoint, was one of the first plans to pull out of the Medicare HMO market across the entire state.[65]

Potential Effects of Premera Conversion

Over the past five to eight years, all major health plans in the Washington and Alaska markets have become much more selective in their decisions about which markets to participate in and which individuals to insure. Moreover, insurance premiums in most market segments have been increasing 10-20 percent annually in recent years. These two trends have affected access to insurance in the individual market, in some rural communities, and (in Washington) in the Medicaid and Basic Health programs.

Effect on premiums.— A converted Premera will likely become more aggressive in using underwriting and benefit design to avoid or manage costs, and may increase premiums, both of which would affect access to insurance. Predictive analyses have warned that premiums for Blues health plans would rise after conversion, although empirical research from publicly available information has not yet been conducted to verify these predictions. The possibility that a converted Premera would raise premiums or more aggressively exclude individuals with medical needs (raising premiums for specific populations can also be a strategy for reducing enrollment in those populations) stems from a relatively simple logic: an investor-owned health plan must generate returns for investors, which must come from either higher premiums, lower provider payments, less care, or some greater overall efficiency. Information reviewed for this report does not support the notion that conversion (or consolidation) results in economies of scale or other indicators of efficiency or that converted health plans systematically reduce provider payments. Therefore, to generate investor returns, a converted Premera would have to seek higher premiums or reduce the proportion of premiums it spends on care.

Effect on accessibility and affordability.— A converted Premera may withdraw from unprofitable markets in order to maximize benefits to shareholders, which could create access problems. The likelihood that a converted Premera would be purchased by a national firm raises even greater longer-term access issues. The primary focus of accountability for a national for-profit health plan is its investors, which will likely reduce a purchased Premera's willingness to continue to serve unprofitable markets that now depend heavily on it (e.g., individual, rural). To the extent a converted Premera becomes even more aggressive in its underwriting practices and more selective in which markets to participate, access to insurance would be lessened. Of particular concern would be access for low-income, rural, small group, and non-group coverage individuals, especially those with significant health care needs, such as people with disabilities, and those who are disproportionately uninsured, such as people of color. This potential could increase an already growing uninsured population and could also increase demand on public programs—such as Medicaid and SCHIP, that are facing additional reductions in the face of state budget cuts—that are alternative sources of coverage for otherwise uninsured people,.

Effect on populations most likely to be directly affected.—The individual and small group markets are most vulnerable to selection bias (that is, the possibility that an insurer will enroll a disproportionate number of people with high cost medical needs) and, so, most likely to be the targets of aggressive underwriting, benefit design, and premium increases. In Alaska, these strategies of a converted Premera could reduce affordability and availability of insurance for the

nearly 11,000 people covered by Premera individual products and 13,000 covered in small group policies. Another 25,000 and 12,000 who are covered by other health plans in these two markets, respectively, could also be affected if Premera's competitors also raise premiums or change underwriting and benefit design strategies.
In Washington, the conversion would most directly threaten coverage for the 48 percent of the individual market (67,000 people) and 35 percent of the small group market insured by Premera. But as noted in Report 1, Premera's influence—and, therefore, potential adverse effects of conversion—is more pronounced in certain counties. It is the only provider of individual coverage in 7 counties (all small and rural) and one of only two in another 17 counties.

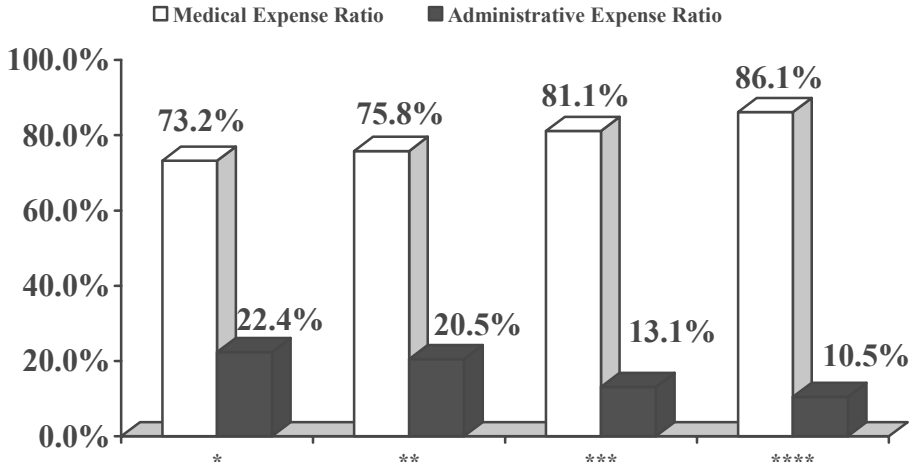
Potential Effects on Quality

In recent years, much emphasis in the health care system has been on quality improvement. Quality related to health plan actions is difficult to define and measure for two major reasons. First, the science of quality is still inexact and complex, involving some combination of technical measures (for example, avoidable hospitalizations), administrative measures (for example, disenrollment rates), and customer perceptions of service (for example, patient satisfaction). Second, some quality-related indicators may measure factors not in the direct control of or significantly influenced by a health plan (for example, satisfaction with physician care).

Nonetheless, health plans do influence service and care quality through such factors as which providers to contract with, aggressiveness in promoting prevention measures, care management systems (for example, preauthorization requirements), customer relations, or prescription drug formularies. Available information provides some indication that nonprofit and local health plans rate higher on some indicators of quality and customer service than for-profit and national plans.

The previous sections presented information that shows that investor-owned health plans have lower medical spending and higher administrative spending. A 1998 study based on HMO annual reports and physician surveys suggests that low medical loss ratios and high administrative expense ratios are, in turn, related to lower quality ratings. Seventy-six health plans were rated on the extent to which they achieved five preventive care goals established by the U.S. Public Health Service. Each plan was then given a composite rating, from four stars (best) to one star (worst). The results are shown in Figure 11, below.[66]

FIGURE 11. Medical Expense Ratio, Administrative Expense Ratio, and Quality Measures for 76 HMOs



A 1998 study of 82,000 Medicare managed care enrollees by Landon, et al., looked at differences in customer ratings among local and national for-profit and nonprofit health plans. The researchers found that the strongest predictors of plan performance from the customers' point of view were tax status and national affiliation: "[F]or-profit health plans had significantly worse scores on customer service and access composites as well as overall ratings . . . . In addition, national plans, whether for-profit or not-for-profit, had lower average scores on customer service and delivery composites as well as on ratings of care, specialists, and the plan."[67]

The Landon study found that voluntary disenrollment rates in for-profit national plans were twice what they were in nonprofit national plans (14.7 percent vs. 7.7 percent). Satisfaction with personal physicians was similar in nonprofit and for-profit health plans, but it was worse in national plans than in local plans. The authors noted that these findings remained when they took into account differences among regions of the U.S., supporting a conclusion that the relationship of for-profit and national status to lower ratings is because of health plan characteristics rather than the characteristics of the region or market in which they operate.[68] A 2002 study found that patients in nonprofit HMOs were more likely than those in for-profit HMOs to be very satisfied with their overall health care. Furthermore, sick enrollees in for-profit HMOs were more likely than their counterparts in nonprofit plans to report administrative barriers, delayed care, unmet need, and high out-of-pocket expenses.[69]

Not all research on nonprofits and for-profits found significant differences in quality indicators. A study by Landon and Epstein, using self-reporting by health plans providing Medicaid managed care products, found small differences between nonprofit and for-profit health plans on access and quality.[70] The researchers found the two plan types similar in allowing direct access to gynecologists and emergency rooms, collecting and disseminating data about use of hospitals, emergency rooms, and specialist referrals, collecting information on quality, and overall information system development. For-profit plans were somewhat more likely to record a Medicaid beneficiary's primary language and to review overall quality data. For-profits were also somewhat more likely to require pre-authorization from a primary care provider for

specialty care or diagnostic tests, and less likely to share quality information with providers in order to translate findings into practice. Overall, the authors said the two types of health plans appear more similar than different in quality management-related activities.

Potential Effects of Premera Conversion

Premera's performance on quality indicators, for which data are available only for Washington's public programs, has been about average among health plans. Available information reviewed for this report provides some indication that nonprofit and local health plans rate higher on some indicators of quality and customer service than for-profit and national plans. If Premera is allowed to convert, patient satisfaction, customer service, and attention to certain prevention measures could drop, and reports of administrative barriers and delayed care could increase. On the other hand, some national research suggests that a converted Premera might focus more energy on providing information to patients concerning care management and on patient-focused information systems.

Effects on Community Benefits

Available information suggests that nonprofit health plans are more likely than for-profits to provide benefits to the community, including supporting safety net services, targeting programs to low-income neighborhoods, and providing more charitable contributions.[71]

Community benefits are those benefits that accrue to the larger community as a result of an organization's activities, beyond the specific goods or services that the organization provides. These benefits include charity care, maintenance of needed but unprofitable services, research, outreach to disenfranchised populations, the "sentinel effect" (for example, setting a high community standard of quality), non-health care economic activities (such as providing employment and purchasing goods and services from local businesses), and non-health community services (such as use of an organization's facilities for community meetings). Nonprofit status has also been viewed as synonymous with being trustworthy (for example, that the patient's well-being will be the highest priority).[72] Community benefits provided by health plans are often informal and difficult to measure.[73]

One example of a community benefit that is given in both the literature and interviews is the benefit of having a plan that is willing to come to the table to discuss ways to meet important policy goals, such as reducing the number of uninsured. Researchers in the North Carolina case interviewed experts who said it was "easier to regulate nonprofits and to 'get them to work for the public good,' since you can 'ask more of nonprofits' regarding pricing and access for vulnerable groups."[74]

A consumer advocate in North Virginia reported that beginning in the late 1980s, BCBSVA had worked with the state to develop innovative options to cover more individuals and businesses, and was even exempted from some of the state's mandated benefit rules. Although the plan lost money on the venture, the interviewee wistfully remembered that there had been "an insurer immediately willing to try these things." Today, some view Trigon (owned by Anthem) as too focused on its bottom line to ever participate in such a collaborative effort.[75] At least one other interviewee in another state echoed this feeling.

Yet, a for-profit or national plan may be motivated to continue involvement in attempts to achieve public goals. For example, WellPoint in Georgia "has strong reasons to stay in good political graces of public officials in order to continue receiving a large contract to administer the public employee health insurance program."[76] WellPoint's business strategy centers around innovative product design, which could potentially lead to fewer uninsured.

One potential risk of conversion is job loss. Anthem has kept its administrative services in states where it acquires health plans, but it has also reduced other employment in those states. In Colorado, where the Blues plan was failing financially prior to conversion, employment was decreased "substantially."[77] Job loss was also cited as a concern in the Maryland conversion case.[78]

Potential Effects of Premera Conversion

Community benefits are those benefits that accrue to the larger community as a result of an organization's activities, beyond the specific goods or services that the organization provides. In other words, by definition community benefits do not directly contribute to an organization's bottom line, so an investor-owned health plan would likely be less focused on such activities. Based on the limited information available for this report, a converted Premera might be expected to:

- Be less likely to subsidize safety net and other community services or to target programs to low-income neighborhoods
- Provide less general philanthropy
- Be less supportive of medical and other health professions education

HPAP did not have access to information concerning Premera's current level of community benefits and, therefore, cannot quantify any expected effects of conversion on community benefits.

Local Ownership and Control

National Ownership

The record over the past 15 years strongly suggests that a Blues health plan that converts will then become or be bought by a national company. Of the cases identified for this report, 13 of the 16 Blues plans that converted to for-profit organizations are now owned by either Anthem or WellPoint (see Table 1, p. 6). As one national expert explained, once converted, a Blues plan is looking either to "acquire or be acquired"[79] for many of the same reasons for the conversion itself: further perceived economies of scale; expanded product offerings; being able to serve multi-state employers; diversifying risk across markets and regulatory settings; and countering the consolidation and market power of other plans.[80] Loss of "localness" matters to the extent that local ownership translates into more concern for, responsiveness to, and sensitivity toward local conditions and community needs. In other words, loss of "localness" may exacerbate some of the problems that are created by the conversion.

The tendency for converted health plans to merge with or be purchased by a larger insurer was borne out in a review of demutualized life insurers conducted in the North Carolina case. It found that the biggest risk for an investor-owned company is "stall out"—that is, its financial performance and growth will stagnate—which often leads to acquisitions and mergers:

> Non-public companies that "stall" simply stay in that mode until something changes—the environment, management, etc. But a publicly owned company that "stalls" will have a marginalized stock price which will make it a more attractive acquisition candidate by another carrier, particularly if the target company has excess capital. The degree of control that BCBSNC now enjoys over its own destiny as a nonprofit organization will therefore diminish to some degree if it converts to for-profit status. For example, it may not be able [to] assure its ability to remain as a stand-alone insurer headquartered in NC . . . .
>
> Three of the top five best-performing demutualization stocks, and five of the top ten, have since been acquired or merged, or an acquisition is pending. In most of those cases, the companies sold because their growth rates slowed. In all cases, the decision to sell rather than to stall out was value-creating for the companies' shareholders.[81]

One example of the conversion-then-acquisition process involved Wisconsin's Blue Cross Blue Shield organization. The CEO of Cobalt Corporation said publicly that it had no plans to be purchased after conversion, but "when WellPoint approached us, we had a fiduciary responsibility to our shareholders to investigate the offer."[82] WellPoint purchased Cobalt less than two years after the plan converted to a for-profit company. Likewise, when asked to comment on the likelihood of a converted Blue Cross and Blue Shield of North Carolina being bought by a larger, out-of-state company, an interviewee said that "there is little doubt" that an acquisition or merger would take place.[83] A similar opinion was voiced by an expert regarding the Virginia conversion case—that the "writing was on the wall" that the Blues plan would not last as a state-run plan for long.[84]

Another national expert interviewed for this report suggested that Anthem and WellPoint may be employing a new strategy in which they wait until a conversion is approved before announcing plans to acquire. She suggested that the vastly different experiences of Anthem and WellPoint in the neighboring states of Maryland and Virginia might have been an important lesson.[85] In Maryland, WellPoint tried to acquire CareFirst as part of a conversion, but the proceedings were drawn out and the company's proposal was eventually denied. In Virginia, the Blues plan had already converted to investor-owned Trigon in 1997. Anthem's subsequent purchase of Trigon was approved in 60 days. At least three important reasons exist for this strategy of delaying acquisition until after conversion: (1) the buyer avoids being embroiled in the regulatory process concerning conversion; (2) the buyer may be able to provide increased value to shareholders or executives by avoiding having to give up funds to a resulting conversion foundation; and (3) it allows the local plan to argue that it intends to remain local, thus removing an argument against conversion.

In one of the few reports to shed light on the difference between a locally owned and a nationally owned for-profit, interviewees regarding the Georgia conversion case said the initial conversion of Blue Cross and Blue Shield of Georgia (BCBSG) to Cerulean had not changed the plan's

corporate culture or behavior, but the sale to WellPoint had "a discernible effect," especially when WellPoint replaced the health plan's senior management.[86] Some interviewees also said that BCBSG had been better to work with than other insurers until the sale to WellPoint.[87] A consumer advocate in Virginia, comparing for-profit Trigon with its buyer, Anthem, stated that "if there was damage, it had already been done" by the initial conversion. But he reported that since the buy out by Anthem, Trigon is no longer just "the big elephant, but the aggressive elephant."[88]

Health Plan and Provider Relations

Information from other states in which conversions have occurred or proposed suggests that conversion of a health plan can increase tensions in relations between health plans and providers, which may be exacerbated in the subsequent acquisition by a national for-profit. The relationships between providers and the two national Blues plans, WellPoint and Anthem, have been the focus of concern, especially evidenced by a national lawsuit brought by physicians. Other factors—such as the Blues' historical dependency on broad provider networks—can mitigate the likelihood that a converted health plan will take a more aggressive negotiating stance with providers.

The willingness of health care providers to contract with a health plan and the ability of a health plan to contract with sufficient numbers and types of providers can affect the ability of the plan's enrollees to obtain necessary care. Thus, how a health plan approaches its relations with providers can be an indication of future access problems. Provider relations include how much a health plan pays providers for the care of its enrollees, as well as the extent to which the plan seeks contract concessions from providers and requires providers to accept financial risk for the costs of care.

Information collected and reviewed for this report reveals a complicated picture of factors that affect relations between a health plan and a provider, only one of which is the profit status of the plan. Said another way, whether a converted health plan's growth and profit-oriented business strategy will negatively affect provider relationships may be "primarily as a function of market share and business strategy, not the corporate form of the insurer."[89]

From a market structure standpoint, how a health plan approaches relations with providers is, in part, a function of the relative power each party has. In a market in which one health plan covers a very large share of a provider's patients, the plan may be able to dictate or otherwise obtain favorable contract and payment terms. Likewise, if one provider system is very large in a market, it may be able to gain concessions from health plans.

Other factors, however, may play important roles, including the historically close relationships Blue Cross Blue Shield health plans have had with providers, state geography, state regulatory oversight, and the extent of consumer and purchaser demand for low rates, choice, and easy access to providers and services. For example, a sole community hospital whose patient population includes a high proportion of Medicaid (that is, low-paying) and uninsured (that is, no-paying) individuals relies on commercially insured patients to maintain financial viability. As a result, the hospital may not use its market power to negotiate aggressively with a Blues health plan on which it depends for higher rates of payment.[90] Likewise, a dominant Blues

health plan might not try to drive down payment rates for a hospital if that would threaten the hospital's financial well-being and, therefore, access to care for the plan's enrollees.

Multiple interviewees and reports from other states have pointed out that the success of many BCBS plans, especially as they increase their national accounts, depends on having broad provider networks.[91] Researchers in the North Carolina case explain that a "large membership base in a geographic area is needed in order to develop and sustain a broad provider network, and that network then becomes a competitive advantage to further grow and maintain market share."[92]

The financial status of a health plan may also affect its approach to provider contracting. For example, Blue Cross Blue Shield of Kansas stood on shaky financial ground at the time it proposed converting. A study conducted for the Kansas Insurance Department predicted that if allowed to be acquired, BCBSK would either have to raise premiums or constrain provider rates in order to create enough profits to both cover the losses and pay shareholders.[93]

Interviews regarding the cases of proposed, but not completed conversions reveal both concern that conversion would lead to more difficult health plan and provider relations and that pre-conversion health plan behaviors had already affected those relationships. Interviewees in the North Carolina case said that "the company already is driving such hard bargains that conversion would not change what it could negotiate with providers since BCBSNC could not get any tougher than it already is." One representative of the Maryland State Medical Association said doctors there were "already at the bottom of the barrel" and that if WellPoint squeezed anymore "it would trash its provider network."[94] However, a Maryland Hospital Association executive reported that providers were very concerned that conversion would lead to much greater insurance market consolidation and, thus, tougher bargaining strategies by the converted plan.[95] Others who felt that BCBSNC had thus far been leaving "some bargaining power on the table" feared that a converted plan would attempt to make new gains.[96]

National Plans and Provider Relations

The conceptual framework regarding accountability for this study suggests that national health plans might be less sensitive and responsive than locally owned plans to the concerns of local health care providers. This potential was voiced by a medical society executive who observed that when Anthem pushes through policies the medical society disagrees with, "they tell us the decision was made in Indiana, and there's nothing they can do about it."[97] Information presented in this section suggests some support for this theory. However, the behavior of national health plans is not entirely predictable; some interviewees representing hospitals and providers described Anthem and WellPoint as "aggressive" but also "fair," and "no worse than the others" when it comes to negotiating with providers.[98]

A recent, national, class action lawsuit reflects concern on the part of health care providers over their relations with national for-profit health plans. Nineteen medical societies and associations around the nation, representing 700,000 doctors, sued eight national for-profit plans alleging late payment, improper claims denials, unfair use of market power to secure contracts unfavorable to providers, and colluding with doctors to reduce the amount of patient care.[99] Aetna reached a $170 million settlement with 18 state medical associations in May 2003 in which the health plan agreed to share its fee schedules and payment rules with physicians, adopt a clearer definition of

"medical necessity," abide by fair payment rules, and establish a independent process through which to address billing disputes. Cigna also settled out of the lawsuit, but six other insurers, including Anthem and WellPoint, remain as defendants in the suit.[100]

WellPoint

WellPoint has had difficulty in negotiations with hospitals and providers in some states. Providers interviewed for the North Carolina case described WellPoint as "hardnosed," "ruthless," and "notorious" in provider negotiations.[101] In 1997, WellPoint was sued by the California Medical Association and 13,000 doctors and is now part of the nationwide class action lawsuit mentioned earlier.[102]

The 2000 HMO Performance Assessment Survey of Southern California physician and hospital organizations showed WellPoint ranking lower than nonprofit Blue Shield of California on 8 of 13 measures scored by providers. WellPoint was rated as the worst plan by 13 percent of providers and the best plan by 5 percent of providers. According to hospitals, WellPoint ranked lower than Blue Shield on 12 of 14 activities, and was listed as the worst plan by 46 percent of hospital respondents and the best plan by only 7 percent.[103]

In a provider survey conducted for the Maryland conversion case, 58 percent of California doctors said that WellPoint was worse or much worse on provider satisfaction than other insurers; 17 percent said WellPoint was better than average; and 66 percent said that turnaround time for authorization was worse than average. Doctors in Georgia, where the conversion was much more recent, seemed more split on WellPoint, with many saying that the plan was on par with others.[104]

Strained relations between WellPoint and hospitals have disrupted care for many Californians, although which side is most responsible is unclear. In November 2002, 22,000 members were affected by a disagreement with Scripps Clinic. In October 2002, a contract negotiation stalemate with six network hospitals in southern California meant that WellPoint enrollees had to be redirected for care.[105]

Anthem

Anthem has also faced some friction with providers in some states. In New Hampshire, where Anthem has upwards of 50 percent market share, a medical society executive said that Anthem was using its dominant position to drive up premiums for employers and to reduce provider rates. He claimed that Anthem had reduced provider rates in some rural communities by 20-25 percent, leading to an "open battle" with a group that oversees two rural hospitals in the state's Lakes Region.[106] Anthem also threatened to discontinue enrollee coverage for 200 doctors who had admitting privileges only at these two hospitals if the hospitals failed to accept the contract, potentially affecting access for many enrollees.[107] Anthem also has been sued in state court by 7,000 doctors in Connecticut who claim that the plan deals unfairly with providers on claims and reimbursement.[108]

Reports from Maine are somewhat mixed. For example, the Maine Medical Association opposed the sale of BCBS of Maine to Anthem, but they now say that they "can't say Anthem is the worst thing that has ever happened to this state" and that Anthem is a "better corporate citizen" than other national plans Cigna or Aetna.[109]

Approach to Legislative and Regulatory Affairs

In general, states have primary regulatory authority over health insurers. As a result, all health plans, nonprofit and for-profit, are involved to one extent or another in advocating for or against specific legislation and regulatory decisions. Information reviewed for this report provides some indication that converting health plans adopt approaches to legislative and regulatory affairs that are more focused on their economic self-interest. As with earlier discussions, the specific approaches vary by state and issue.

The researchers in the North Carolina case found that, before conversion, Missouri's Blue Cross (BC) plan had become:

> much less socially oriented in its legislative and public policy positions. Regulators said that BC began to oppose it more often and actively on various regulatory and legislative issues. Consumer advocates agreed, noting that at one time BC was the only major insurer to "come to the table" to discuss systemic reform such as solutions to the uninsured or problems created by risk segmentation. But, now, it is like any commercial insurer that just looks out for its own interests in the public policy arena and tried to protects [sic] its ability to make money.[110]

One consumer advocate from Missouri described the original conversion in his state as "a very discouraging 'watershed'" that "ratified or cemented the flaws of the current system and 'gave up the ghost' of any realistic hope for systemic or fundamental reform."[111] In Maine, where the state's Blues plan had been acquired at the point of conversion, a consumer advocate claimed that Anthem had successfully "gutted" the state's modified community-rating laws and pre-existing condition policies.[112]

Because of the differing circumstances from state to state, an individual national health plan sometimes pursues different legislative strategies in different states. Anthem took opposite positions on legislation in Colorado and New Hampshire that would have allowed for modified community rating as well as rating on health status and industry.

Historically, Colorado's nonprofit BCBS plan had opposed further modified community rating and the weakening of benefit mandates. But in 2003, Anthem, the new owner of BCBSCO, supported new legislation that would allow plans to adjust rates by 15 percent up or down based on health status, medical claims, and smoking. It also supported legislation to allow slimmer benefit packages, exempt from some state benefit mandates, to be sold by health plans.[113] On the other hand, in New Hampshire, where Anthem had *supported* similar legislation four years ago, the plan was the most visible opponent during the 2003 session. Newspaper articles and interviewees from New Hampshire suggest that Anthem was trying to protect its 70 percent market share from new competitors it feared the bill would entice to enter the state's market.[114]

In addition to the specific effects of conversion on regulatory and legislative affairs, it is important to note that state regulators potentially have considerable authority over the conversion or acquisition process of nonprofit Blues plan. This is lost once a health plan converts.

Potential Effects of Premera Conversion

Premera is a homegrown health insurance company serving the states of Washington and Alaska since 1945 and 1957, respectively. Throughout its history, Premera has participated in nearly every market segment in both states, including individual, small group, and large group (both insured and self-funded), rural and urban, and public programs for low-income individuals in the case of Washington. It has long-standing relationships with health care providers, brokers, employers, other health plans, and policy makers in both states.

Some of the more significant effects if Premera converts from a nonprofit to an investor-owned, for-profit company stem from the high likelihood that it will subsequently be purchased by a national for-profit firm.[b] An investor-owned company has a fiduciary responsibility to its shareholders to consider a buy-out offer regardless of any intentions it may have to remain independent. Of the cases identified for this study, 13 of 16 Blues plans that converted are now owned by either Anthem or Wellpoint. The recently announced merger of these two national health plans would create a $36 billion company with 26 million covered lives[115], a large base from which to pursue further purchases. In fact, Anthem CEO Larry Glasscock has noted that the growth-through-acquisition strategy shared by both companies was a reason the merger is a good fit.[116]

Experience and theory suggest that a converted Premera will focus more on national markets than on the unique circumstances of markets, consumers, and providers in Alaska and Washington. The particular market circumstances of Alaska and rural Washington (relatively large role of public sponsors, large Premera market share) make this focus of special concern. The implications of a converted, and then purchased Premera fall into three categories:

> ***More contentious relations with providers***—Financial demands driven by investor expectations will likely draw Premera into more contentious interactions with physicians, hospitals, and other providers over contract terms and payment issues.[c] If a converted, national Premera becomes a more aggressive negotiator and is able to reduce provider payment rates, providers may then seek to compensate by seeking higher payments from other health plans. If successful, those plans may, in turn, seek higher premiums. Higher premiums would harm the policy holders of other insurers and may make coverage unaffordable to some individuals.
>
> Alternatively, if other health plans also become tougher negotiators, provider revenues could be cut. Providers that are in a difficult fiscal condition (such as rural medical clinics[117], small community hospitals) may then limit services to low-paying clients (such as Medicaid, Medicare) or cease operations, in turn potentially impeding access to care for some patients.

[b] We refer to the potential acquisition of Premera by a national health plan to include a scenario in which a converted Premera proceeds to acquire other health plans in the region and nationally, thus *becoming* a national for-profit health plan. In either case, the accountability of the health plan would shift from policy holders and local communities to regional markets and investors.

[c] Although investor demands would affect a converted Premera even if it is not purchased, the lawsuits involving national, for-profit health plans described earlier suggest this issue could be even greater if Premera is acquired.

Loss of local service focus—A national firm could be expected to move Premera's state-based service centers to regional or national sites. Such a decision could reduce service levels. Concerns expressed by providers in Alaska and eastern Washington about the perceived insensitivity of Premera's Seattle-based decisions is one indication of how relations might be affected should a converted Premera be acquired by a national company. Acquisition could also result in a loss of local jobs.

Less community-focused legislative and regulatory strategies—Premera has been an active player in health policy discussions in both Washington and Alaska. For example, Premera was one of the primary stakeholders in the process that led to changes in 2000 to Washington state law concerning the individual market. This debate was long and contentious, but Premera's large presence in that market was a strong motivation for the health plan to seek resolution of those health policy issues. A national company might have less staying power in such a policy debate, choosing instead to exit that market or product line—after all, individually purchased coverage accounts for a very small part of the whole insurance market nationally or in any particular state and, importantly, a very small proportion of any health plan's revenues (the individual market accounts for less than 10 percent of Premera's enrollment in both Alaska and Washington).

Should a converted and purchased Premera greatly reduce its enrollment in the individual market, much more of the demand—and, therefore, risk and burden—of that market would then fall on Regence, Group Health, and other health plans; these plans might then either raise premiums to compensate for that greater risk, limit enrollment, design products to attract the least costly enrollees, or exit the individual market entirely. The result of such a scenario would be less affordable and less available coverage for as many as 300,000 consumers Washington (the number of people who had individually purchased coverage prior to the crisis in that market in the late 1990s) and the 30,000 people now in the individual market in Alaska, including many with significant medical conditions.

A national Premera might also be less supportive of state policy initiatives designed to improve overall access to health services or health insurance or to strengthen community health infrastructure. In 1987, then-Blue Cross of Washington and Alaska was a strong supporter of efforts in the Washington State Legislature to create the Basic Health Plan. This novel program of state-subsidized health insurance for the working poor has played a major role in the state's success in reducing the uninsured population during the 1990s. Support from the major insurers was important in getting the BHP enacted and implemented. A national health plan may not expend the political resources to support such an access initiative in only one of many states in which it operates.

V. CONCLUSION

If Premera's request to convert to an investor-owned company is approved, residents of Alaska and Washington can expect reduced access to health insurance, especially for those in the individual market and people with greater medical need, and less spending on health care (versus other expenses, such as administration and profit) by Premera as a percentage of premiums. A converted Premera might also exhibit somewhat lower quality indicators for those it insures and might provide fewer community benefits.

If Premera is acquired or becomes a regional or national health plan through acquisitions or mergers, these effects would likely be more pronounced. In addition, providers could also expect more contentious interactions over contract and payment terms, and state policy makers could expect less involvement and collaboration in solving access and other issues.

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